		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029132

Facility Name: COMMUNITY CARE CENTER

Address: 4314 WABASH AVENUE (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: 773538-8300 **Fax #** (773) 538-5775

IDPA ID Number: 36-3327511

Date of Initial License for Current Owners: 11/26/1984

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,554	4,554	8
9	SNF/PED					9
10	ICF	64,881	16	74	64,971	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,881	16	4,628	69,525	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.37%

D. How many bed-hold days during this year were paid by Public Aid?
1,579 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/26/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/26/84 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 4,554

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	238,285	25,759	20,417	284,461		284,461	0	284,461			1
2	Food Purchase		259,788		259,788		259,788	(6,014)	253,774			2
3	Housekeeping	135,790	22,736	0	158,526		158,526	0	158,526			3
4	Laundry	105,683	17,675	177	123,535		123,535	0	123,535			4
5	Heat and Other Utilities			122,746	122,746		122,746	526	123,272			5
6	Maintenance	78,901	38,020	69,265	186,186		186,186	4,339	190,525			6
7	Other (specify):* SECURITY	20,527		25,550	46,077		46,077	148	46,225			7
8	**TOTAL General Services**	579,186	363,978	238,155	1,181,319	0	1,181,319	(1,001)	1,180,318			8
	B. Health Care and Programs											
9	Medical Director	0		3,000	3,000		3,000	0	3,000			9
10	Nursing and Medical Records	1,720,207	68,604	19,951	1,808,762		1,808,762	0	1,808,762			10
10a	Therapy	128,358		1,758	130,116		130,116	0	130,116			10a
11	Activities	0	11,599	2,416	14,015		14,015	0	14,015			11
12	Social Services	169,846		2,302	172,148		172,148	0	172,148			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):* SEE SCHEDULE	57,866			57,866		57,866	(12,500)	45,366			15
16	**TOTAL Health Care and Programs**	2,076,277	80,203	29,427	2,185,907	0	2,185,907	(12,500)	2,173,407			16
	C. General Administration											
17	Administrative	73,750		600,000	673,750		673,750	(579,137)	94,613			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			127,971	127,971		127,971	4,869	132,840			19
20	Dues, Fees, Subscriptions & Promotions			25,457	25,457		25,457	(367)	25,090			20
21	Clerical & General Office Expenses	74,966	3,676	116,132	194,774		194,774	(18,970)	175,804			21
22	Employee Benefits & Payroll Taxes			333,442	333,442		333,442	0	333,442			22
23	Inservice Training & Education			1,485	1,485		1,485	124	1,609			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			3,032	3,032		3,032	866	3,898			25
26	Insurance-Prop.Liab.Malpractice			119,135	119,135		119,135	4,470	123,605			26
27	Other (specify):* SEE SCHEDULE	43,396		535,040	578,436		578,436	(523,080)	55,356			27
28	**TOTAL General Administration**	192,112	3,676	1,861,694	2,057,482	0	2,057,482	(1,111,225)	946,257			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,847,575	447,857	2,129,276	5,424,708	0	5,424,708	(1,124,726)	4,299,982			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COMMUNITY CARE CENTER #0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			73,604	73,604		73,604	55,293	128,897			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			11,996	11,996		11,996	331,023	343,019			32
33	Real Estate Taxes				0		0	147,945	147,945			33
34	Rent-Facility & Grounds			776,580	776,580		776,580	(776,580)	0			34
35	Rent-Equipment & Vehicles			34,218	34,218		34,218	5,530	39,748			35
36	Other (specify):*				0		0	56,353	56,353			36
37	**TOTAL Ownership**			896,398	896,398	0	896,398	(180,436)	715,962			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		126,710	170,174	296,884		296,884	0	296,884			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			111,690	111,690		111,690	0	111,690			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	126,710	281,864	408,574	0	408,574	0	408,574			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,847,575	574,567	3,307,538	6,729,680	0	6,729,680	(1,305,162)	5,424,518			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(46,344)	30		9
10	Interest and Other Investment Income	(2,266)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,200)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,814)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(600)	20		17
18	Fines and Penalties	(4,434)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(8,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(535,040)	27		24
25	Fund Raising, Advertising and Promotional	(744)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(12,466)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (615,908)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(689,254)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (689,254)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,305,162)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COMMUNITY CARE CENTER

ID# 0029132

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 34	6	1
2	MARKETING SALARIES	(12,500)	15	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(12,466)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,014)	0	0	0	0	0	0	0	0	0	0	(6,014)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	526	0	0	0	0	0	0	0	526	5
6	Maintenance	34	0	2,835	1,470	0	0	0	0	0	0	0	4,339	6
7	Other (specify):*	0	0	148	0	0	0	0	0	0	0	0	148	7
8	**TOTAL General Services**	(5,980)	0	2,983	1,996	0	0	0	0	0	0	0	(1,001)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(12,500)	0	0	0	0	0	0	0	0	0	0	(12,500)	15
16	**TOTAL Health Care and Programs**	(12,500)	0	0	0	0	0	0	0	0	0	0	(12,500)	16
	C. General Administration													
17	Administrative	0	(579,137)	0	0	0	0	0	0	0	0	0	(579,137)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,000)	615	12,130	124	0	0	0	0	0	0	0	4,869	19
20	Fees, Subscriptions & Promotions	(1,344)	0	977	0	0	0	0	0	0	0	0	(367)	20
21	Clerical & General Office Expenses	(4,434)	9,518	(24,578)	524	0	0	0	0	0	0	0	(18,970)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	124	0	0	0	0	0	0	0	0	124	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	650	216	0	0	0	0	0	0	0	0	866	25
26	Insurance-Prop.Liab.Malpractice	0	1,112	3,223	135	0	0	0	0	0	0	0	4,470	26
27	Other (specify):*	(535,040)	3,992	7,968	0	0	0	0	0	0	0	0	(523,080)	27
28	**TOTAL General Administration**	(548,818)	(563,250)	60	783	0	0	0	0	0	0	0	(1,111,225)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(567,298)	(563,250)	3,043	2,779	0	0	0	0	0	0	0	(1,124,726)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(46,344)	427	545	1,253	99,412	0	0	0	0	0	0	55,293	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,266)	0	596	1,887	330,806	0	0	0	0	0	0	331,023	32
33	Real Estate Taxes	0	0	0	1,191	146,754	0	0	0	0	0	0	147,945	33
34	Rent-Facility & Grounds	0	0	0	(15,300)	(761,280)	0	0	0	0	0	0	(776,580)	34
35	Rent-Equipment & Vehicles	0	1,869	3,661	0	0	0	0	0	0	0	0	5,530	35
36	Other (specify):*	0	0	0	0	56,353	0	0	0	0	0	0	56,353	36
37	**TOTAL Ownership**	(48,610)	2,296	4,802	(10,969)	(127,955)	0	0	0	0	0	0	(180,436)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(615,908)	(560,954)	7,845	(8,190)	(127,955)	0	0	0	0	0	0	(1,305,162)	45

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
YOSEF DAVIS	50	SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
MORRIS ESFORMES	50			EMI ENERPRISES	LINCOLNWOOD	MGMT CONSULTA
				IME REALTY	LINCOLNWOOD	HOME OFFICE
				RSM		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 600,000	EMI ENTERPRISES, INC		$	$ (600,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				20,863	20,863	4
5	V	19	ACCOUNTING FEES				615	615	5
6	V	21	OFFICE EXPENSE				9,518	9,518	6
7	V	25	TRANSPORTATION				650	650	7
8	V	26	INSURANCE				1,112	1,112	8
9	V	27	EMPLOYEE BENEFITS				3,992	3,992	9
10	V	30	DEPRECIATION				427	427	10
11	V	35	AUTO LEASE				1,869	1,869	11
12	V								12
13	V								13
14	Total			$ 600,000			$ 39,046	$ * (560,954)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 72,000	EKS MANAGEMENT, INC.		$	$ (72,000)	15
16	V								16
17	V								17
18	V	6	PAINTING SALARIES				2,835	2,835	18
19	V	7	SCAVENGER				148	148	19
20	V	19	PROFESSIONAL FEES				12,130	12,130	20
21	V	20	WANT ADS				977	977	21
22	V	21	OFFICE EXPENSE				47,422	47,422	22
23	V	23	SEMINARS				124	124	23
24	V	25	TRANSPORTATION				216	216	24
25	V	26	INSURANCE				3,223	3,223	25
26	V	27	EMPLOYEE BENEFITS				7,968	7,968	26
27	V	30	DEPRECIATION				545	545	27
28	V	32	INTEREST - INSUR. FIN.				596	596	28
29	V	35	EQUIPMENT RENT				3,661	3,661	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,000			$ 79,845	$ * 7,845	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		34	OFFICE RENT	$ 15,300	IME REALTY CORP.		$	$ (15,300)	15
16	V									16
17	V									17
18	V		5	UTILITIES				526	526	18
19	V		6	REPAIRS & MAINTENANCE				1,470	1,470	19
20	V		19	PROFESSIONAL FEES				124	124	20
21	V		21	OFFICE EXPENSE				524	524	21
22	V		26	INSURANCE				135	135	22
23	V		30	DEPRECIATION				1,253	1,253	23
24	V		32	INTEREST				1,887	1,887	24
25	V		33	RE TAX				1,191	1,191	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 15,300			$ 7,110	$ * (8,190)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 761,280	RSM NURSING ASSOCIATES		$	$ (761,280)	15
16	V	30	DEPRECIATION				99,412	99,412	16
17	V	32	INTEREST				330,806	330,806	17
18	V	33	REAL ESTATE TAXES				146,754	146,754	18
19	V	36	AMORT.-DEFERRED MORT. COSTS				56,353	56,353	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 761,280			$ 633,325	$ * (127,955)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BERNARD COHEN	GENERAL PARTNE	ADMINISTRATION		SEE ATTACHED SCHEDULE			MGMT FEE	$	17-3	1
2	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION					SALARY		17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	616,513	11	$ 185,000	$ 185,000	69,525	$ 20,863	1
2	19	ACCOUNTING FEES	PATIENT DAYS	616,513	11	5,451		69,525	615	2
3	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	84,399	60,672	69,525	9,518	3
4	25	TRANSPORTATION	PATIENT DAYS	616,513	11	5,763		69,525	650	4
5	26	INSURANCE	PATIENT DAYS	616,513	11	9,863		69,525	1,112	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	35,399		69,525	3,992	6
7	30	DEPRECIATION	PATIENT DAYS	616,513	11	3,788		69,525	427	7
8	35	AUTO LEASE	PATIENT DAYS	616,513	11	16,569		69,525	1,869	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 39,046	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MGMT,
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING SALARIES	PATIENT DAYS	616,513	11	$ 25,141	$	69,525	$ 2,835	1
2	7	SCAVENGER	PATIENT DAYS	616,513	11	1,310		69,525	148	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	616,513	11	107,563		69,525	12,130	3
4	20	WANT ADS	PATIENT DAYS	616,513	11	8,660		69,525	977	4
5	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	420,511	316,407	69,525	47,422	5
6	23	SEMINARS	PATIENT DAYS	616,513	11	1,100		69,525	124	6
7	25	TRANSPORTATION	PATIENT DAYS	616,513	11	1,912		69,525	216	7
8	26	INSURANCE	PATIENT DAYS	616,513	11	28,579		69,525	3,223	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	70,657		69,525	7,968	9
10	30	DEPRECIATION	PATIENT DAYS	616,513	11	4,837		69,525	545	10
11	32	INTEREST - INSUR. FIN.	PATIENT DAYS	616,513	11	5,286		69,525	596	11
12	35	EQUIPMENT RENT	PATIET DAYS	616,513	11	32,463		69,525	3,661	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 316,407		$ 79,845	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	203,249	12	$ 6,990	$	15,300	$ 526	1
2	6	REPAIRS & MAINTENANCE	INCOME	203,249	12	19,525		15,300	1,470	2
3	19	PROFESSIONAL FEES	INCOME	203,249	12	1,650		15,300	124	3
4	21	OFFICE EXPENSE	INCOME	203,249	12	6,958		15,300	524	4
5	26	INSURANCE	INCOME	203,249	12	1,798		15,300	135	5
6	30	DEPRECIATION	INCOME	203,249	12	16,647		15,300	1,253	6
7	32	INTEREST	INCOME	203,249	12	25,074		15,300	1,887	7
8	33	RE TAX	INCOME	203,249	12	15,815		15,300	1,191	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 7,110	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RSM NURSING ASSOCIATES
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD,IL 67012
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	30	DEPRECIATION	DIRECT	1	1	99,412		1	99,412	2
3	32	INTEREST	DIRECT	1	1	330,806		1	330,806	3
4	33	REAL ESTATE TAXES	DIRECT	1	1	146,754		1	146,754	4
5	36	AMORT.-DEFERRED MORT. COS	DIRECT	1	1	56,353		1	56,353	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 633,325	$		$ 633,325	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LASALLE BANK		X	MORTGAGE	QUARTERLY	9/15/96	$ 7,500,000	$ 0		0.0800	$ 299,196	1
2	LASALLE BANK		X	MORTGAGE	$46,308.00	12/3/01	6,350,000	6,350,000	12/3/08	0.0735	31,610	2
3	RELATED PARTY										2,483	3
4												4
5												5
	Working Capital											
6	LASALLE NATIONAL BANK		X	WORKING CAPITAL	INTEREST	REVOLV.	0	0	REVOLV	PRIME+	11,996	6
7												7
8												8
9	TOTAL Facility Related				$46,308.00		$ 13,850,000	$ 6,350,000			$ 345,285	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 13,850,000	$ 6,350,000			$ 345,285	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	170,203	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	158,584	2
3. Under or (over) accrual (line 2 minus line 1).	$	(11,619)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	158,584	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 211 For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	(211)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	146,754	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	163,085	8
	1997	168,364	9
	1998	171,353	10
	1999	170,203	11
	2000	158,584	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029132

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-03-300-010-0000	NURSING HOME	$ 839.16	$ 839.16
2.	20-03-300-012-0000	NURSING HOME	$ 839.16	$ 839.16
3.	20-03-300-021-0000	NURSING HOME	$ 3,572.75	$ 3,572.75
4.	20-03-300-022-0000	NURSING HOME	$ 37,329.05	$ 37,329.05
5.	20-03-300-023-0000	NURSING HOME	$ 38,097.42	$ 38,097.42
6.	20-03-300-024-0000	NURSING HOME	$ 37,540.18	$ 37,540.18
7.	20-03-300-025-0000	NURSING HOME	$ 36,773.38	$ 36,773.38
8.	20-03-300-026-0000	NURSING HOME	$ 3,592.99	$ 3,592.99
9.			$	$
10.			$	$
		TOTALS	$ 158,584.09	$ 158,584.09

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,088 B. General Construction Type: Exterior FRAME Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 98,640	1
2					2
3	TOTALS			$ 98,640	3

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1985	57,320					57,320	9
10	VARIOUS			1986	12,387	826	15	826		10,129	10
11	VARIOUS			1987	4,819	153	31.5	153		3,059	11
12	VARIOUS			1988	948	30	31.5	30		543	12
13	VARIOUS			1989	3,644	116	31.5	116		1,880	13
14	VARIOUS			1992	6,146	195	31.5	195		2,289	14
15	VARIOUS			1993	17,589	558	31.5	558		5,381	15
16	UNDERGROUND PLUMBING			1994	1,607	41	39	41		319	16
17	DOORS			1994	630	16	39	16		115	17
18	NURSING STATION			1995	3,000	77	39	77		536	18
19	INSTALLED BATH TUB			1995	8,606	221	39	221		1,478	19
20	ROOF REPAIR			1995	14,900	382	39	382		2,531	20
21	FLOOR COVERING			1995	9,876	253	39	253		1,727	21
22	ROOF WORK			1996	2,200	56	39	56		311	22
23	INSTALL NEW PUMP UNIT, CAR DOOR FOR ELEVATOR			1997	18,215	467	39	467		2,098	23
24	FURNISH & INSTALL BASE, VINYL - 3RD FLOOR			1997	38,100	977	39	977		4,356	24
25	INSTALL NEW MODIFIED ROOF SYSTEM			1997	5,150	132	39	132		1,412	25
26	CHAIN LINK FENCE			1998	3,723	248	15	248		775	26
27	FRONT ENTRY DOOR			1998	1,793	46	39	46		167	27
28	GREASE TRAP & TILES			1998	4,300	110	39	110		371	28
29	FIREDAMPERS WITH SLEEVES			1998	4,279	110	39	110		353	29
30	SEAL UP CRACKS AROUND THE BUILDING			1998	3,900	100	39	100		321	30
31	PLUMBING			1999	7,200	185	39	185		455	31
32	CEMENT AND ASPHALT WORK			1999	5,900	151	39	151		359	32
33	WALL PAPER			2000	5,155	1,262	7	1,262		1,999	33
34	BOILER			2000	4,537	165	27.5	165		172	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AUDIT RCI GENERATOR	1986	$ 8,181	$		$	$	$ 8,181	37
38	AUDIT SUMP PUMP	1986	414					414	38
39	AUDIT EXHAUST FAN	1986	1,132					1,132	39
40	AUDIT CABINETS	1987	9,462					9,462	40
41	NURSING STATION	2001	24,600	484	27.5	484		484	41
42	DOORS	2001	6,867	135	27.5	135		135	42
43	TILING	2001	12,958	2,592	5	2,592		2,592	43
44	CARPETING	2001	6,344	1,269	5	1,269		1,269	44
45									45
46	RELATED PARTY			1,028		1,028			46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 315,882	$ 12,385		$ 12,385	$ 0	$ 124,125	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 567,706	$ 43,110	$ 10,851	$ (32,259)	10 YRS	$ 143,284	71
72	Current Year Purchases	81,737	16,347	5,052	(11,295)	10 YRS	5,052	72
73	Fully Depreciated Assets				0		348,516	73
74	RELATED PARTY	380,454	39,244	39,244	0	10 YRS	285,338	74
75	TOTALS	$ 1,029,897	$ 98,701	$ 55,147	$ (43,554)		$ 782,190	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY BUSINESS	BUS	1985	$ 600	$ 0	$	$ 0	3 YR	$ 600	76
77	FACILITY BUSINESS	79 GMC JIMMY	1988	2,994	0		0	5 YR	2,994	77
78	FACILITY BUSINESS	CHEVY	1990	24,000	2,790		(2,790)	5 YR	24,000	78
79							0			79
80	TOTALS			$ 27,594	$ 2,790	$ 0	$ (2,790)		$ 27,594	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,472,013	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 113,876	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,532	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (46,344)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 933,909	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 34,218 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			SEE SCHEDULE		18
19			ATTACHED		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$ 4,500	$ 4,500
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 4,500	$ 4,500
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 82,335	$		$ 82,335	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			157			157	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			87,682			87,682	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs				10,425		10,425	8
9	Pharmacy	39-2	# of prescrpts				79,925		79,925	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY, LABORATORY Other (specify): MEDICAL SUPPLIES	39-2 39-2					10,004 26,356		10,004 26,356	13
14	TOTAL			$		$ 170,174	$ 126,710		$ 296,884	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COMMUNITY CARE CENTER **#** 0029132 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,686	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,458,123		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	152,070		6
7	Other Prepaid Expenses	51,318		7
8	Accounts Receivable (owners or related parties)	310,737		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,066,934	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	296,693		15
16	Equipment, at Historical Cost	677,037		16
17	Accumulated Depreciation (book methods)	(638,216)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 335,514	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,402,448	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 700,757	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,736		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,446		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO R.S.M.	1,007,436		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,910,375	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,910,375	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,492,073	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,402,448	$ 0	48

***(See instructions.)**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,147,022	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(77,815)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,069,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,342,866	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(920,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	0	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 422,866	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,492,073	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,972,206	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,972,206	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,874	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 93,874	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,266	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,266	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	4,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,072,546	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,181,319	31
32	Health Care	2,185,907	32
33	General Administration	2,057,482	33
	B. Capital Expense		
34	Ownership	896,398	34
	C. Ancillary Expense		
35	Special Cost Centers	296,884	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,729,680	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,342,866	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,342,866	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,571	1,654	$ 37,200	$ 22.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,414	6,897	139,528	20.23	3
4	Licensed Practical Nurses	39,989	42,541	730,003	17.16	4
5	Nurse Aides & Orderlies	94,201	101,291	745,501	7.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,020	12,523	128,358	10.25	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	19,108	21,231	169,846	8.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,920	33,609	238,285	7.09	15
16	Dishwashers					16
17	Maintenance Workers	6,406	6,537	78,901	12.07	17
18	Housekeepers	20,480	22,261	135,790	6.10	18
19	Laundry	13,817	15,184	105,683	6.96	19
20	Administrator	2,082	3,358	73,750	21.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,729	10,134	74,966	7.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,996	6,312	67,975	10.77	31
32	Other Health Care(specify)					32
33	Other(specify) Schedule attached	8,312	8,857	121,789	13.75	33
34	TOTAL (lines 1 - 33)	270,045	292,389	$ 2,847,575 *	$ 9.74	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 17,888	1-3	35
36	Medical Director	O	3,000	9-3	36
37	Medical Records Consultant	N	3,163	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,841	10-3	39
40	Physical Therapy Consultant	L	1,479	10a-3	40
41	Occupational Therapy Consultant	Y	279	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,416	11-3	44
45	Social Service Consultant	E	2,302	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,368		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		2,236		52
53	TOTAL (lines 50 - 52)		$ 2,236		53

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DENISE MARTIN	ADMIN		$ 73,750
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,750

B. Administrative - Other

Description	Amount
M. ESFORMES	$ 300,000
Y. DAVIS	300,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 600,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		127,971
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 127,971

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 49,283
Unemployment Compensation Insurance		32,729
FICA Taxes		217,399
Employee Health Insurance		23,469
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,837
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		8,725
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 333,442

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,734
Health Care Worker Background Check	2,940
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	744
TRUST FEES/FRANCHISE TX/ETC	600
RELATED PARTY WANT ADS	977
DUES & SUBSCRIPTIONS	11,289
LICENSES & PERMITS	3,950
TRUST FEES/FRANCHISE TX/ETC	(600)
Less: Public Relations Expense	(0)
Non-allowable advertising	(744)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,090

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1997	$ 4,662	3 YR	$ 1,554	$ 1,554	$ 777	$	$	$	$	$	$
2	PAINT/DECORATING	1998	2,164	3 YR	361	721	721	361					
3	PAINT/DECORATING	1999	2,544	3 YR		424	848	848	424				
4	PAINT/DECORATING	2000	6,787	3 YR			1,132	2,262	2,262	1,131			
5	PAINT/DECORATING	2001	4,125	3 YR				688	1,375	1,375	687		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 20,282		$ 1,915	$ 2,699	$ 3,478	$ 4,159	$ 4,061	$ 2,506	$ 687	$	$

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $11,220**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **787** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: COMMUNITY CARE CENTER **#0029132** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	17,888	
	REPAIRS & MAINTENANCE		2,529	
			0	20,417
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		177	
				177
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		43,704	
	ELECTRICITY		52,221	
	WATER		24,832	
	CABLE TV - LOBBY		1,989	
			0	122,746
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,890	
	PAINTING & DECORATING		4,125	
	BUILDING REPAIRS		9,634	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		28,550	
	ELEVATOR MAINTENANCE & REPAIR		9,995	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,700	
	FIRE SERVICE		5,024	
	CONTRACTED BLDG MAINTENANCE		(653)	
			0	
			0	69,265
7	**OTHER**			
	SCAVENGER		17,834	
	SECURITY SERVICE		7,716	25,550
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	3,000	3,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	2,236	
	LABORATORY & XRAY EXPENSE		1,000	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	1,411	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,163	
	PHARMACY CONSULTANT	XVIII B 39-2	8,841	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		3,300	
			0	19,951
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,479	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	279	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,758
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,416	
			0	2,416
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,302	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,302
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COMMUNITY CARE CENTER **#0029132** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	600,000	600,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,311	
	ADMINISTRATIVE CONSULTANTS	XIX C	60,000	
	PROFESSIONAL FEES	XIX C	47,660	
			0	127,971
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	744	
	EMPLOYEE WANT ADS	XIX F	5,734	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	11,289	
	LICENSES & PERMITS	XIX F	4,150	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	600	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,940	25,457
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		1,917	
	OUTSIDE CLERICAL SERVICES		74,384	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,434	
	HOME OFFICE EXPENSE		17,578	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,819	
	MESSENGER SERVICE		0	
			0	116,132

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	217,399	
	UNEMPLOYMENT COMPENSATION	XIX D	32,729	
	WORKERS COMPENSATION INSURANC	XIX D	49,283	
	HOSPITALIZATION INSURANCE	XIX D	23,469	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,837	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	8,725	333,442
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,485	1,485
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,032	3,032
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		119,135	119,135
27	**OTHER**			
	BAD DEBTS	VI 24	535,040	
				535,040

GRAND TOTAL COLUMN 3 OTHER 2,129,276

COMMUNITY CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	259,788	PATIENT MEALS	208575
LESS SALES TAX	1,814	ADD EMPLOYEE MEALS	0
NET FOOD	257974	TOTAL MEALS/YEAR	208575
TOTAL PATIENT CENSUS	69,525	NET FOOD	257974
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	208575
TOTAL PATIENT MEALS	208575	COST PER MEAL	1.24
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		